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The Australian Psychological Society Ltd

Psychological Wellbeing of Refugees Resettling in Australia

A Literature Review prepared for The Australian Psychological Society

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Abstract

This literature review was developed as background for the formulation of an Australian Psychological Society position on the mental health and wellbeing of refugees resettling in Australia. The major aim is to provide a broad overview of the concerns related to refugee mental health and wellbeing within the Australian context. To begin, a brief overview of the definition of a refugee and the scope of refugee movement is provided. Next, the review examines the pre-displacement, post-displacement, systemic and socio-political factors that influence the process of adaptation in refugee resettlement. It then reviews documented approaches to psychological assessment and therapeutic interventions with refugees; and finally it summarises suggestions for assessment and intervention in these practice contexts.

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Psychological Wellbeing of Refugees Resettling in Australia: A Literature Review

At the end of 2006, there were 9.9 million refugees worldwide, with an even larger 32.9 million persons of concern (UNHCR, 2007a). According to the United Nations 1951 Convention on the status of refugees, a refugee is:

> a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable or unwilling to avail himself/herself of the protection of that country, or to return there, for fear of persecution (Article 1).

There are three durable solutions outlined by the international governing body for refugees, the United Nations High Commissioner for Refugees (UNHCR): voluntary repatriation; local integration in the country of first asylum; and third country resettlement. Resettlement in a third country is the least common durable solution (less than 1% of all refugees) given the high cost and extreme burden placed on refugees and the host countries (UNHCR, 2003). However, it has been shown to be one of the most effective solutions in bringing protection to refugees and constitutes a significant number of refugees and resources involved in the resettlement countries. According to the UNHCR, through the federal humanitarian programs in 2006, 71,700 refugees were admitted by 15 resettlement countries, with the largest numbers being resettled in the United States, Australia, Canada, Sweden, Norway and New Zealand respectively (2007a). Australia admitted 13,400 of those refugees through their off-shore, family reunification and other humanitarian programs (UNHCR, 2007a).

Refugees who enter Australia through the humanitarian programs are typically identified by the UNHCR and enter through Australia's government-sponsored humanitarian program in which they are provided with initial supports such as assistance in finding accommodation, language training, access to Medicare and mental health care, and financial supports. Other refugees may enter Australia by having a family member or another individual or group sponsor their entrance to the country. The non-government sponsored group is provided with access to most of the humanitarian supports, but it is assumed that the sponsor will take care of initial concerns such as housing and transport.

Still others enter Australia without a government-issued visa of any kind. Such individuals who are awaiting verification that they meet the United Nations 1951 Convention Article 1 definition of refugee are referred to here as refugee claimants. They are also called asylum seekers, who have filed claims for protection by Australia from persecution in their home country after arriving in this country without a visa. Between 1992-2008, refugee claimants, upon arrival in Australia, were compulsorily detained. Some were subsequently released from immigration detention into the community on a range of temporary or bridging visas available under legislation.

Temporary Protection Visas (TPVs) may be granted to persons to whom the government owes protection under the international refugee convention.[1] Temporary Humanitarian Visas (THV) may be awarded to persons arriving in Australia who have been processed through Australia's offshore humanitarian program. Bridging Visas (BV) may be awarded to refugee claimants while their visa application is being processed or while they are awaiting the outcome of a court review of an unsuccessful visa application. BV holders may or may not have work rights. Finally, Return Pending Visas (RPV) for up to 18 months may be awarded to current or previous refugee claimants whose application for protection has been refused, in order to allow them time to prepare for departure and resettlement. Although research that compares permanent and temporary visa holders is available and will be reviewed later, we are unaware of any research that specifically compares the different categories of temporary visa holders with one another. Nor could we be sure that research with TPV holders did not also include in the research sample persons who were in possession of a THV, BV or RPV. Therefore, we have referred to persons from these groups as Temporary Visa (TV) holders in order to acknowledge

[1] The APS welcomes the proposed abolition of TPVs, and looks forward to its enactment in legislation.

that their temporary visa status may differ between persons or over time.

There are also different Australian Federal legislative and policy positions that determine the status and rights of Permanent Protection Visa (PPV) holders, TV holders and refugee claimants who are in immigration detention. None of these legislative and policy differences is the focus of the present review. Please refer to other sources for more detailed overviews of the Australian refugee programs (e.g. Bruce, 2003; Department of Immigration and Citizenship (DIAC), 2007; Jupp, 2003; Neumann, 2004). The present review, instead, has focused on the psychological concomitants of being a refugee, with a view to identifying those aspects of working with refugees and refugee claimants that reflect psychological best practice.

For the purposes of this paper, unless otherwise stated, we will be referring to refugees with either permanent or temporary visa status and to refugee claimants as refugees. We recognise that TV holders and refugee claimants face additional challenges given their unique experiences with the legal system, uncertainty over their tenure in Australia, and the limitations to government support available to them. These special concerns will be addressed later in separate sections, as will the implications of using terms such as 'asylum seekers' to refer to TV holders. However, we maintain that refugee claimants are a unique subgroup of refugees, to whom the overarching themes of this review apply.

This review is meant to provide an overview of the issues related to the mental health of refugees from an evidence-based perspective. It complements the extensive practice resources available from organisations such as the Australian Centre for Posttraumatic Mental Health < http://www.acpmh.unimelb.edu.au> and the Forum of Australian Services for Survivors of Torture and Trauma < http://www.fasstt.org.au> which offer services and other support for people from refugee backgrounds, including people who have been victims of torture and trauma, and for service providers.

The review includes an overview of the current literature, and empirical research related to individual and community, and pre-migration and post-migration factors is provided. We also explore current best practices for assessment, education and therapeutic interventions. We identify strengths and weaknesses in current professional knowledge about, and practice with, refugees and provide recommendations for further advancement of the field. As individuals from around the world continue to settle in Australia, practitioner psychologists must continue to enhance their knowledge and skills to provide the best quality of care possible. The review offers a springboard for continued interest, compassion and advancement in research and practice for refugees in Australia and around the world.

Psychological Impacts of the Refugee Experience

The continuing psychological impacts of trauma experiences prior to resettlement have been a longstanding focus of the refugee literature. Exposure to trauma may lead to a range of psychological reactions, including Posttraumatic Stress Disorder (PTSD). Persons experiencing the psychological effects of trauma may report feelings of fear, sadness, guilt and anger. Psychological sequelae include depression, anxiety and substance misuse. Trauma related syndromes include significant distress or impaired functioning, often involving intrusive thoughts and emotions about the traumatic events, avoidance, emotional numbing and/or hyper-arousal. Consistent and strong links have been made between pre-migration trauma and mental health in resettlement (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1999; Smith, Perrin, Yule, & Rabe-Hesketh, 2001; Steel, Silove, Phan, & Bauman, 2002; Terheggen, Stroebe, & Kleber, 2001). Nevertheless, while acknowledging the importance of specific services for people from refugee backgrounds who have experienced torture and/or other traumatic events, our review also attempts to examine the psychosocial and psycho-educational sequelae of refugees' adverse experiences of forced migration and resettlement, that are not necessarily torture and/or trauma related.

Pre-Displacement and Displacement Factors

Research into the relation between pre-migration trauma and post-migration mental health suggests a dose-response association where the severity of PTSD symptoms increases as refugees' exposure

to traumatic experiences increases (Carlson & Rosser-Hogan, 1991; Fawzi et al., 1997; Kinzie et al., 1990). There are different types of traumatic experiences, such as human rights violations, threats to life, traumatic loss, dispossession and eviction. Such experiences have been found to have differential impacts on mental health. One study by Momartin and colleagues (Momartin, Silove, Manicavasagar, & Steel, 2003) of a refugee sample found that threat to life was a significant predictor of PTSD status, while threat to life coupled with traumatic loss contributed to symptom severity and disability associated with PTSD. In addition, co-morbidity plays a role, where individuals with co-morbid PTSD and MDD have worse long-term outcomes than refugees with either depression or PTSD (Momartin, Silove, Manicavasagar, & Steel, 2004).

The mental health status of refugees in resettlement has held equal attention in the literature. In general, it seems that time is a powerful healer. The prevalence of mental health problems drops significantly over the course of resettlement (Lie, 2002; Steel et al., 2002; Westermeyer, Neider, & Callies, 1989). However, individuals who have experienced high levels of pre-migration trauma may remain at higher risk throughout the course of resettlement. In one population-based study of Vietnamese refugees in New South Wales, individuals who were exposed to higher levels of trauma remained at higher risk of mental illness after 10 years as compared to Vietnamese with no history of trauma exposure (Steel et al., 2002).

Some researchers have suggested a curvilinear pattern, whereby refugees have increasing levels of symptoms in the early stages of settlement, given the demands placed on resources, and then a subsequent decrease in symptoms when those initial stressors have passed. Tran et al. (2007) found depressive symptoms amongst adult Vietnamese American refugees increased over the first 10 to 12 years of resettlement and subsequently decreased. Others have suggested different time frames for experiencing greater levels of distress, including peaks around months 10 to 12 months after resettlement (Beiser, 1988) or the second year of resettlement (Rumbaut cited in Beiser, 1988). The differences in findings across studies suggest the relationship between early and later psychological symptomatology is not necessarily straightforward.

There is similar variation across studies when systematically examining specific clinical disorders. Some research has found higher rates of clinical disorders such as PTSD, MDD and dissociation (Carlson & Rosser-Hogan, 1991; Kinzie et al., 1990) and greater psychological disturbance (Fazel & Stein, 2003; Leavey et al., 2004). In other studies, prevalence rates among refugees are even lower than those of the host population (Beiser & Hou, 2001; Steel et al., 2005). There has been considerable inconsistency in rates of PTSD reported, ranging from 7% to 86% according to some estimates (Fawzi et al., 1997). These variations across studies could be related to a variety of factors including: the wide range of measures and diagnostic cut-offs used; cultural variations in expressions of distress; factors related to specific cohorts (e.g. higher levels of torture and trauma); and research designs (e.g. sampling approach, sample size).

Given these inconsistencies, it is important to look at the larger studies and meta-analyses to make better generalisations about patterns in the data. Meta-analyses allow data to be collapsed across studies, increasing the total sample size and improving statistical power. One meta-analysis examined studies with a total of 7,000 refugees in resettlement (Fazel, Wheeler, & Danesh, 2005). It found prevalence rates for PTSD of 9% and for major depression of 5% among adults (sample size = 6,743; from 20 studies) and for PTSD among children of 11% (sample size = 260; 5 surveys). The authors point out that research to date on prevalence of psychiatric illness among refugees has been widely variable. The studies differ dramatically in terms of the populations studied, sample size, recruitment strategy, and the quality of the research design. In general, they point out that larger studies have lower prevalence rates (Fazel et al., 2005).

Another meta-analysis by Porter and Haslam (2005) combined pre- and post-displacement factors over 56 studies to provide additional insights into the overall trends within those data. In the meta-analysis, Porter and Haslam (2005) found that refugees had worse outcomes than their non-refugee control comparisons (weighted mean effect size = 0.41). They also found that refugees (a) who were in institutional accommodation and had restricted economic opportunity, (b) who were displaced

internally within their own country (i.e. had not been resettled in another country), and (c) whose initiating conflict in their country of origin was unresolved, had worse outcomes. In addition, those who were from rural backgrounds, with higher levels of education, and higher pre-displacement socioeconomic status (SES) had worse outcomes. Importantly, they found that post-displacement factors moderated outcomes. That is, the situations in which refugees were living after they were displaced affected the relationship between their pre-displacement experiences, e.g., trauma, SES, and their post-displacement outcomes.

Some research has investigated the importance of demographic variables for predicting refugee outcomes in resettlement. This approach is useful in understanding risk profiles for people who may need additional psychological screening or services but caution must be exercised when relying on generalisations. In most cases, this research has shown that being an older refugee or a woman results in worse outcomes in resettlement (Majka & Mullan, 1992; Porter & Haslam, 2001, 2005; S. M. Weine et al., 1998). Qualitative research has shown that older adults may have special concerns related to feelings that they are "aging in the wrong place" (Hugman, Bartolomei, & Pittaway, 2004).

Characteristics of families and family processes have been implicated in outcomes, particularly in relation to the adjustment of children and adolescents in resettlement. Among children, family is a key mediator of risk factors on outcomes (Rousseau & Drapeau, 1998). That is, when parents are mentally healthy, there are low levels of stress within the family and high levels of cohesion, and children are better able to adapt to their new host country (Birman et al., 2005; Hjern & Angel, 2000; Rousseau, Drapeau, & Corin, 1998). Arriving with both parents is also a strong predictor of positive adjustment (Montgomery, 1998). The power of family as a resource has been emphasised (Beiser, 1991; Miller & Rasco, 2004) and reinforces the priorities of family reunification in resettlement programs.

Post-Displacement Factors

An increased focus on resettlement issues and post-migration stressors is apparent in recent research, marking a shift away from the earlier focus on pre-migration trauma. Indeed, these are the factors that can be addressed and changed via individual and community interventions in the resettlement environs. This research has shown that post-migration stressors can have a significant impact on settlement outcomes. One study with Tamil asylum seekers, refugees and immigrants in Australia found that while pre-migration trauma exposure accounted for a significant amount (20% of the variance) of posttraumatic stress symptoms, so too did post-migration stress (14% of the variance) (Steel, Silove, Bird, McGorry, & Mohan, 1999).

The experience of loss in resettlement has been linked to mental health outcomes among refugees. Individuals who had higher levels of education in their home country or who had decreases in their socioeconomic status in resettlement have worse outcomes (Porter & Haslam, 2005). Similarly, those who report a loss of meaningful social roles and loss of important life projects (Colic-Peisker & Walker, 2003; Miller, 1999), report lower levels of daily activity (Miller et al., 2002), are unemployed or facing economic hardship (Beiser & Hou, 2001; Canadian Task Force, 1988; Lavik, Hauff, Skrondal, & Solberg, 1996; Pernice & Brook, 1996; Simich, Hamilton, & Baya, 2006) and/or report being socially isolated (Miller et al., 2002; Mollica et al., 2001; Pernice & Brook, 1996), are all at risk of worse outcomes in resettlement. Silove (1999) suggests reactions in the post-trauma environment are manifest in their impact on five core adaptive systems including systems of safety, attachment, justice, identity-role, and existential meaning.

Post-migration difficulties may also be a result of the particular refugee's compatibility with the host culture and the nature of the resettlement program. The nature of the Australian humanitarian program may interact with various individual characteristics and circumstances to affect refugee responses in resettlement. Colic-Peisker and Tilbury (2003) suggest that active ('achievers' and 'consumers') versus passive ('endurers' and 'victims') approaches to resettlement by the refugees may interact with host community reactions to refugees. They suggest that medicalisation of the refugee experience in Australia may encourage refugees to take on a passive role (Colic-Peisker & Tilbury, 2003) which may decrease the likelihood of positive post-migration outcomes. The interaction between person and environment in resettlement cannot be overlooked.

This interaction is also manifest in the access and utilisation of various community services across ethnic groups. Several writers suggest that the lack of cultural fit between traditional western psychotherapy and refugee beliefs about mental health and psychological disorders are among the most significant barriers to traditional mental health programs when such programs are available (Kemp, 2006; Miller, 1999; Steel et al., 2005). Accordingly, refugees tend to rely more on the medical system than on mental health services for relieving symptoms of psychological distress (Brainard & Zaharlick, 1989). Among refugees, PTSD predicts greater numbers of somatic complaints and organ systems involved in the complaints, regardless of symptoms of depression and anxiety (van Ommeren et al., 2002).

Adjustment to geographical and cultural relocation requires considerable attention and energy from refugees in the beginning stages of resettlement. Almost overnight, individuals find themselves confronted by, amongst other things, a new language, cultural values and worldviews, foods and traditions, paperwork and systems of business and currency. Particularly with recent changes in the countries of origin for refugees entering Australia's humanitarian program, the "cultural gap" (Berry, Poortinga, Segall, & Dasen, 2002) between Australian society and incoming refugees has grown even larger. That is, refugees now entering Australia tend to be even more disparate in cultural norms and lifestyle when compared to earlier waves of refugees, such as those from Eastern Europe.

Individuals and ethnic minority groups vary in the extent to which they maintain their cultural and ethnic heritage and in the degree to which they interact with the larger society when entering a new country. According to models of acculturation (Berry et al., 2002), individuals and minority ethnic groups are considered to integrate, assimilate, separate, or to be marginalised within the larger society. Literature with immigrants and refugees suggests that newcomers who integrate into mainstream society have better outcomes than those who approach resettlement differently (Berry et al., 2002; Spasojevic, Heffer, & Snyder, 2000; Valtonen, 1994; Young, 1996). However, these studies have largely been done within societies that encourage newcomers to integrate into the mainstream society, which may confound these results. For refugee children and adolescents in Australia, those who had the most positive attitudes toward both their culture of origin and Australian culture had the highest ratings of self-worth and peer social acceptance (Kovacev, 2004).

When adapting to Australia, refugees are faced with a sudden loss of identity and subsequent demands to reconstruct themselves within the new context (Colic-Peisker & Walker, 2003). Individuals, family members and cultural groups vary in the rate and degree to which the new identity changes to become more similar to norms that apply within mainstream Australian culture (Sonderegger & Barrett, 2004). This can be a major source of tension and conflict for families, communities and service providers. Families, just like individuals, must reconstruct themselves, with individuals taking on new social roles and responsibilities. Children and adolescents frequently become language brokers as their English skills often advance more rapidly than those of adults. Parental roles change and cultural differences in family structure and discipline may be at odds with Australian norms. Where refugee families are considered to be at risk of domestic violence, partly because of their experiences in forced migration and differences in behavioural norms, culturally appropriate interventions are a necessity (Pan et al., 2006).

Specific Circumstances of Refugee Claimants

Although refugee claimants have had significant media attention in Australia, they represent numerically a small piece of the global pie. In 2006, 3,510 asylum applications were lodged in Australia. This is small in comparison to a total of 303,430 applications lodged in Europe and non-European industrialised nations around the world (UNHCR, 2007b). In the 1990s, 92,800 applications were lodged with Australian authorities and 14.6% (10,400) were accepted and granted residence in Australia (Bruce, 2003). Some Western countries such as Germany, Austria and New Zealand have comparable rates, while other Western countries such as the United Kingdom, Canada and Denmark have acceptance rates that are approximately twice Australia's acceptance rate (UNHCR cited in Bruce, 2003).

While Australia has been repeatedly recognised as having one of the best off-shore humanitarian resettlement programs in the world, there has been equally strong condemnation of its policies on refugee claimants. Claimants seeking asylum must face a number of challenges and obstacles when they enter Australia, including restrictive government policy and negative community opinions and reactions, which are unique to their uncertain status.

Concerns over "queue jumpers," "boat people," and "illegal immigrants" are not necessarily unique to Australia. However, Australia's policy on mandatory detention in recent years drew international criticism as a breach of international human rights agreements of which Australia is a signatory (Bruce, 2003). Although many countries use detention for similar purposes, Australia was the only country where detention was mandatory for all individuals entering without valid visas (Silove, Steel, & Mollica, 2001). As a signatory to international human rights treaties, Australia is required to accept refugee claimants when they arrive on shore and to process their claims. However, the use of other countries nearby, e.g. Nauru, was one approach to circumvent this obligation. In response to criticism, a legislative amendment was passed in 2005, making detention of minors a "last resort" and permitting the federal Minister to make residence determinations for their families which do not involve immigration detention (Commonwealth of Australia, 2005). More recently, the offshore detention facilities at Nauru and Manus Island were closed.

In August 2008, the Federal Cabinet passed the following changes to immigration detention policy with the following seven points:

1. Mandatory detention is an essential component of strong border control.
2. To support the integrity of Australia's immigration program, three groups will be subject to mandatory detention:
   a. all unauthorised arrivals, for management of health, identity and security risks to the community
   b. unlawful non-citizens who present unacceptable risks to the community and
   c. unlawful non-citizens who have repeatedly refused to comply with their visa conditions.
3. Children, including juvenile foreign fishers and, where possible, their families, will not be detained in an immigration detention centre (IDC).
4. Detention that is indefinite or otherwise arbitrary is not acceptable and the length and conditions of detention, including the appropriateness of both the accommodation and the services provided, will be subject to regular review.
5. Detention in immigration detention centres is only to be used as a last resort and for the shortest practicable time.
6. People in detention will be treated fairly and reasonably within the law.
7. Conditions of detention will ensure the inherent dignity of the human person.

From "New Directions in Detention - Restoring Integrity to Australia's Immigration System" Speech given by Senator Chris Evans at Australian National University, Canberra, Tuesday 29 July 2008

Impacts of Mandatory Detention

Research examining the mental health of refugee claimants in immigration detention has shown the deleterious effects of detention. A thorough review of relevant psychological theory and available research findings from international research has resulted in the following conclusions:

- Detention is a negative socialisation experience.
- Detention exacerbates the impacts of other traumas.

Dudley (2003) estimates that the rates of suicidal behaviours among men and women in these Australian detention centres are approximately 41 and 26 times the national average, respectively. Furthermore, male refugee claimants in detention have rates of suicidal behaviour that are 1.8 times higher male prison rates (Dudley, 2003). Steel et al. (2004) assessed parents and children who had been held in Australian immigration detention centres for approximately two years. All of the individuals met diagnostic criteria for at least 1 current psychiatric disorder; 26 disorders were identified among

14 adults, and 52 disorders were identified among 20 children. Mares and Jureidini (2004) confirmed these high levels of psychological distress among adults and children in detention and noted that there was very little support and few interventions provided in those settings. The detention setting places many obstacles in the way of clinicians servicing detainees and making significant improvements in such an impoverished environment is improbable. Refugees' experiences of immigration detention have offered compelling evidence that detention has impeded efforts to address their mental health needs. The Detention Health Advisory Group on which the APS is represented, is developing evidence-based policies and procedures in regard to the health and wellbeing of detainees, particularly around suicide and self harm issues. (Commonwealth of Australia, 2007).

Studies examining the experiences of refugee claimants have also shown high rates of trauma, PTSD, and depression among this subgroup (Silove, 2002). One study, in which 51% of the sample had experienced torture, showed that, similar to other studies with refugees, combined PTSD and MDD was associated with considerable psychosocial disability (Silove et al., 2006). A host of other factors, including a number of policy-related variables like conflict with immigration officials, obstacles to employment and delays in processing of the refugee's application, were associated with psychiatric distress (Silove, Sinnerbrink et al., 1999).

Particular emphasis has been placed on the psychological vulnerabilities of child refugee claimants who have been held in immigration detention. Thomas and Lau (2002) conducted an extensive review of local and international research into the mental health status of children and adolescents who were refugees or were detained in the course of claiming refugee status. Thomas and Lau concluded that symptoms of post-traumatic stress are common amongst child and adolescent refugees.

Although symptoms vary across age groups, in preschoolers, they are generally manifested in very high anxiety, social withdrawal and regressive behaviours. In school-aged children, symptoms can include flashbacks, exaggerated startle responses, poor concentration, sleep disturbance, complaints of physical discomfort and conduct problems. In adolescents, symptoms may include acting out, aggressive behaviours, delinquency, nightmares, trauma and guilt over one's own survival (Thomas & Lau, 2002, p. 3).

The studies they reviewed also offered evidence for a direct relationship between the level of pre-migration trauma to which young people were subjected and their levels of post-migration post traumatic stress. Children who were separated from parents or other caregivers were more likely to exhibit symptoms of depression.

Thomas and Lau (2002) found evidence in the reported research for an inverse linear relationship between the time since the traumatic events occurred and young people's level of post traumatic stress symptoms. Symptoms of traumatic stress decreased over time. However, they noted evidence in the research they reviewed which suggested that parents and other caregivers may underestimate young people's levels of psychological stress and distress, and that young people's levels of psychological dysfunction were related to levels of psychological dysfunction within their families. Their literature review provided strong evidence for the existence of co-morbid physical and psychological symptoms amongst young refugee claimants and for family separations and unaccompanied arrival having a negative influence on young detainees' physical and psychological health and wellbeing.

The Australian Psychological Society's submission (Allan, Davidson, Tyson, Schweitzer, & Starr, 2002) to the National Inquiry into Children in Immigration Detention reached a similar set of conclusions. The submission maintained that holding young people in immigration detention is a negative socialisation experience, accentuates developmental risks, threatens the bonds between children and significant caregivers, limits educational opportunities. In addition, the detention experience has traumatic psychological impacts, reduces the potential to recover from pre-migration trauma, and exacerbates the impacts of other traumas.

The National Inquiry into Children in Immigration Detention (Human Rights and Equal Opportunity Commission, 2004) found evidence in the submissions it received and in first hand accounts of health professionals working with young refugee claimants in detention of: pre-migration trauma; negative

impacts on young people of long-term detention; a compounding effect between that trauma and the impacts of detention; destructive effects of detention on families; a relationship between family functioning and young people's mental health; alarming levels of suicidal ideation and acts of self harm amongst young detainees; alarming levels of MDD and PTSD amongst young detainees; diagnosis of other mental health problems, including anxiety, nightmares, bed wetting, dissociative behaviour, emotional numbing and a sense of hopelessness. Evidence also suggested that the levels of mental health care required by these young people could not be delivered effectively in a detention setting. The inquiry concluded that:

> findings [on the incidence of MDD, PTSD and anxiety disorder amongst young detainees in an Australian detention centre] are consistent with the observations of a range of other experts about the impact of detention on asylum seekers. For example, a recent study from the United States finds that prolonged detention has a lasting negative health impacts [sic] on detainees (Human Rights and Equal Opportunity Commission, 2004, p. 392).

Finally, the inquiry concluded that "the education available to children in detention fell significantly short of the level of education provided to students with similar needs in the community"(p.636); that "on-site detention centre schools failed to develop a curriculum suited to the needs and capabilities of children in immigration detention" (p.636); and that "[c]hildren were inadequately assessed as to their educational needs, and there was insufficient reporting of [their] educational progress" (p.637).

Impacts of Temporary Visas

Similarly, the Temporary Visa (TV) policy has been associated with psychiatric distress among refugee claimants released into the community on a temporary visa. Studies comparing rates among TV and PPV holders show they have equivalent levels of previous trauma; however, TV holders tend to exhibit greater levels of psychiatric symptoms (Momartin et al., 2006). In one study, being previously detained or being under temporary protection contributed independently to risk of ongoing PTSD, depression and mental health-related disability (Steel et al., 2006). Longer detention was associated with more severe mental disturbance, an effect that lasted on average for 3 years following release into the community (Steel et al., 2006). The insecurity of tenure and living with fear of forced removal significantly decreases wellbeing among TV holders (Rees, 2003). Refugees on TVs have not had free access to government sponsored job networks, English language tuition, income support, health assessment, a health care card, settlement services, and tertiary education (Davidson, et. al., 2004). They also report that it is harder for them to access healthcare services (Silove, Steel, McGorry, & Drobny, 1999).

The use of TVs also affects the efforts of service providers when working with TV holders in the community. Refugees who have temporary status have a range of special concerns and needs, such as legal concerns, and needs created by gaps in commonwealth programming for individuals on TVs, such as access to health care and ESL courses. Often, agencies are unprepared and under-resourced to address those special concerns (McNevin & Correa-Velez, 2006), and the funding and infrastructure to support those needs must be developed from the bottom up in each community. Differential access to services also adds to confusion among TV holders as well as among service providers as to who is entitled to which services (N. Davidson et al., 2004).

The TV and mandatory detention policies are two prominent examples of the compounding of pre-migration trauma by the "anti-humanitarian" nature of the treatment received by some refugees in the Australian setting over the past fifteen years. Future governments need to ensure that applications are processed quickly and that immediate access to appropriate support services is always available for these persons (Rees, 2003).

Community and Systemic Factors

The review, thus far, has identified a host of factors relating to individual and group differences between individuals and families that influence their experiences in refugee resettlement. However, one should not narrowly examine the experiences of individuals without taking account of the systems and communities that surround refugee resettlement, and of how the social and cultural environment affects the individual's experience of resettlement. Although the themes, processes and outcomes highlighted above will be relevant when examining community factors, researchers and service providers must also understand the macro-level factors independently in order to have a clearer picture of the dynamic and multi-level nature of refugee resettlement.

A critical influence on resettlement is the host country's attitudes towards immigrants and refugees. Similar to changes that occur within the immigrant individual or group, members of the host society can also vary in the extent to which they maintain their original cultural and ethnic identity and the relationships they seek across groups. Australian attitudes toward newcomers have vacillated over the last 100 years, as evidenced by public policy and community opinions (Neumann, 2004).

Refugee experiences in Australia and in other countries around the world are arguably linked to the receptions they receive in the host countries. Psychologists need to understand that interventions can only work within systems that recognise and reduce experiences of oppression which limit growth and wellbeing. These influences range from overt prejudice and discrimination to subtle systemic prejudice and discrimination. For example, the use of terminology to refer to various groups can play a role in influencing public attitudes toward refugees. One such study examined the terminology used by media, pointing out that the social categorisation of individuals as "boat people" and "illegal immigrants" can encourage marginalising practices (O'Doherty & Lecouteur, 2007).

Research examining host community social perceptions of refugees suggests that attitudes and perceptions of threat are a real concern in Australia. Social psychological research has shown that Australians' support for harsh, exclusionary treatment of refugee claimants increases if they perceive that (a) their social status and position are threatened by admitting these claimants, (b) refugee claimants do not have a legitimate claim to residency, and (c) social attitudes toward refugee claimants are generally negative. These opinions are mediated by perceptions of procedural (e.g., fairness of regulations and policies) and distributive (e.g., quality of life deserved by refugee claimants versus Australian citizens) justice (Louis, Duck, Terry, Schuller, & Lalonde, 2007). Among college students, males had less favourable attitudes than females toward refugees, and realistic and symbolic (e.g. differences in norms, values, etc.) threats were associated with prejudicial attitudes (Schweitzer, Perkoulidis, Krome, Ludlow, & Ryan, 2005).

A series of studies by Pedersen and colleagues (Hartley & Pederson 2007; Pedersen, Attwell, & Heveli, 2005; Pedersen, Clarke, Dudgeon, & Griffiths, 2006; Pedersen, Watt, & Hansen, 2006) have focussed on Australians' attitudes and opinions toward asylum seekers (sic) and related government policy. Strong relationships were found between holding negative attitudes toward asylum seekers and endorsement of false beliefs about them, such as asylum seekers being queue jumpers, illegal, 'cashed up', and not genuine. Gender, educational level, political orientation and endorsement of nationalistic values predicted community attitudes, while educational level, political orientation, endorsement of nationalistic values and age predicted endorsement of false beliefs. Clear comparisons exist between negative attitudes toward both asylum seekers and Indigenous Australians. Holding opinions that the community at large is stable and that refugee claimants' actions are legitimate signalled more favourable opinions about asylum seekers and less favourable opinions about government policy. These findings suggest that 'asylum seeker' has a pejorative meaning for many Australians. Our use of 'refugee claimant' attempts to avoid those negative connotations.

Another major systemic issue facing refugees pertains to difficulties with navigating the educational system. There is no current comprehensive national policy for the education of refugee children and adolescents (Christie & Sidhu, 2002), and to date there has been relatively little empirical evaluation within the school setting. Despite high numbers of refugee children coming to Australia with little

to no formal schooling, there are no standardised interventions for these children when they enter the Australian school systems and the experiences of children will be highly variable across teachers and schools. Most children are entered into age-appropriate classrooms, regardless of their prior schooling experience, knowledge or educational performance. This results in major obstacles for students, particularly those entering at higher levels of the school system. A number of initiatives have been trialled; however, there is a "need for an over-arching education policy and funding agenda which acknowledges the complexity of the multiple systems involved in educating refugee children, if symbolic rights to education are to be translated into actual opportunities" (Christie & Sidhu, 2002).

Additional challenges arise when refugee children's physical abilities and interactions with peers affect their school performance (Driver & Beltran, 1998). Symptoms associated with experiences of trauma often include difficulty concentrating, memory disturbances, anxiety and depression. Emotional problems have been shown to be related to learning difficulties and academic achievement (Rousseau, Drapeau, & Corin, 1996). Pryor (2001) offers specific recommendations for addressing the personal and educational needs of diverse students within the school system. She argues that schools should recognise the unique contributions immigrant and refugee children can provide within the classroom.

Adult refugees face similar educational challenges. Refugees who enter through the humanitarian program are entitled to up to 510 hours of English language training. However, there are some limitations and restrictions on those hours and a number of grass roots volunteer literacy and tutoring services have developed to help satisfy unmet language learning needs. Other writers have identified barriers to accessing higher education and the lack of recognition of overseas qualifications as major limitations for adult refugees arriving in Australia (Hannah, 1999). It is critically important that steps are taken to ensure appropriate training or verification of previous skills and certifications to enable smooth transitions into education and employment for adult refugees coming to Australia.

Establishing access and equity across services for refugees requires an examination of the special needs of refugee communities from an organisational perspective. Several recommendations have been made to help overcome current injustices, such as making available training programs for service providers (Singh, 2005). For organisations that feel adequate training is already in place, checklists for achieving adequate levels of multicultural proficiency have been proposed by Dana and Matheson (1992) and Davidson (1999). Other new technologies such as videoconferencing may be implemented to train employees in more remote locations (Ekblad et al., 2004). This model has been adopted in several State mental health programs and should become standard practice. Training opportunities are already available through agencies such as Foundation House, the Centre for Multicultural Youth Issues and migrant resource centres.

Assessment and Intervention

Assessment

Assessment is a cornerstone of training for psychologists, and the development and adaptation of measures to assess culturally and linguistically diverse populations adequately is an area that has sparked controversy over the years (G. R. Davidson, 1997; Suzuki, Ponterotto, & Meller, 2001). There are several measures that have been adapted and validated for use with refugee populations (see Table 1 for a representative list of adapted and validated assessment measures). Campbell (2007) provides additional information on the use of the clinical interview, the Allodi Trauma Scale, the Semistructured Interview for Survivors of Torture, and the Harvard Trauma Questionnaire for assessing PTSD with torture survivors. A range of translated clinical and psychosocial assessment tools for use with individuals from migrant and refugee backgrounds is also available through the Victorian Transcultural Psychiatry Unit at http://www.vtpu.org.au/resources/translatedinstruments/. Adapting measures from tests that have been previously developed and evaluated with other populations must be done with caution because the measures may provide very different sets of norms, and may not accurately capture the experiences of the new sample. For example, in assessing a life event measure of war-related traumas, Hollifield et al. (2005) question whether current evaluations are comprehensive.

Western mainstream researchers developing measures must ensure the new measure adequately covers the topic of concern.

Further, there is considerable debate about the applicability and appropriateness of western concepts (and current measures) for use with non-western populations (Miller et al., 2006; Terheggen et al., 2001). For instance, the applicability of PTSD, with its western ontology and values, is currently controversial (Bracken, Giller, & Summerfield, 1995; Kagee & Naidoo, 2004). Some researchers recommend that psychologists look beyond a focus on PTSD and the victimisation of refugees (Muecke, 1992) in order to examine the broader context and various dimensions that are a part of the lives of refugees (Brough, Gorman, Ramirez, & Westoby, 2003). Therefore, when assessing the experiences of refugees, measures must move beyond measures of PTSD and pathology to examine the breadth of the human experience in resettlement.

Measures of educational aptitude and achievement need to be modified in ways that recognise the unique experiences and educational history of newly arrived refugee students (Dao, 1991). Many refugees come from highly aural cultures, where there is less emphasis and training in written knowledge and understanding (Burgoyne & Hull, 2007). Dao (1991) highlights five issues that need to be addressed for refugee students in school settings: linguistic and cultural background; acculturation problems; literacy and basic skill levels; problem-solving skills; and emotional difficulties.

A number of other factors must also be considered when assessing refugee populations. The presence of psychological disorders such as PTSD has been linked to poorer cognitive functioning among adult refugees (Kivling-Boden & Sundbom, 2003). Physical injuries (e.g., brain injury, malnutrition) and psychological distress (e.g., depression, PTSD) may actually modify the chemical and physical composition of the brain. Weinstein et al. (2001) highlight the possibility of fixed neural loss and neuropsychological abnormalities that are triggered by traumatic events and further influenced by ongoing stress. They highlight the need for neuropsychologists to assess the impact of traumatic brain injury and experiences of torture and trauma with tools that are culturally sensitive (Weinstein et al., 2001).

Assessment of memory and recall is critical to the processing of refugee claims and the aforementioned issues in cognitive impairment apply to assessment in this domain. Only a few studies have examined complications in assessment when evaluating refugee claims. One study examined inconsistencies in refugee claimants' reports across interviews to determine whether those errors should serve as indicators of lack of credibility. The research found that discrepancies often occurred when individuals were interviewed on multiple occasions. The number of discrepancies for individuals with high levels of posttraumatic stress increased with increasing time between the interviews. In addition, there was greater divergence in the details refugee claimants rated as peripheral to their account than in the details they rated as central to their claims (Herlihy, Scragg, & Turner, 2002).

One study of the Canadian system for reviewing refugee claims recognised the process as "one of the most complex adjudication functions in industrialised societies" (Rousseau, Crepeau, Foxen, & Houle, 2002, p. 43). In this study, the researchers examined 40 difficult cases that were referred to the research team. In reviewing already decided cases, they found a number of issues including: "difficulties in evaluating evidence, assessing credibility, and conducting hearings; problems in coping with vicarious traumatisation and uncontrolled emotional reactions; poor knowledge of the political context, false representations of war, and cultural misunderstandings or insensitivity" (Rousseau et al., 2002, p. 43). The issues surrounding the complexity of refugee claims need to be addressed and systematic procedures and training are a necessity for conducting a fair review.

In summary, psychological assessment with refugees is largely undeveloped (Ehntholt & Yule, 2006). The need for advances in assessment spans many disciplines and services, from school systems, disability evaluations, cognitive functioning, mental health status and medical evaluations, to evaluations related to refugee claims. Further work is required for the purpose of developing culturally sensitive and appropriate measures of refugees' cognitive functioning, mental health status, psychopathology, educational ability and educational attainment. Greater emphasis might be given to the importance of neuropsychological assessment of refugees who have experienced torture, trauma

or physical deprivation. The development of new assessment measures or the adaptation of existing measures should include provision for establishing the validity and reliability of those measures and for norms against which future assessees' performance might be judged.

Interventions

A number of mental health interventions for refugees have been proposed. These interventions have targeted a wide range of ethnic groups and presenting problems, and have been conducted in widely varying contexts. Thus far, several pilot studies, case reviews and small empirical evaluations have been published but there is a noticeable absence of major efficacy trials.

An earlier review of intervention strategies for promoting refugee integration (Schibel, Fazel, Robb, & Garner, 2002) also failed to locate a substantial body of literature relating to any kind of intervention designed to enhance health and welfare among refugee populations. Schibel et al. systematically searched MEDLINE, EMBASE, PsycLIT, PILOTS, PASCAL, OHS, CDSR and the Cochrane Library databases. They located one report of an intervention that employed individual debriefing to reduce and prevent PTSD, which was unsuccessful (Rose, Wessely, & Bisson, 2001). Their search for literature on integration interventions was extended to include the PAIS, SIGLE, SSCI, Sociological Abstracts and University of Oxford Refugee Studies Centre Library databases. The review located only 7 intervention studies that met their criteria of employing randomised or quasi-randomised trials or interrupted time series, with a control, and with a cohort of more than 50 treatment participants who were followed up for a six month period. A further 6 studies reported on interventions but did not meet the methodological criteria for inclusion. Schibel et al. (2002) concluded that although there is a large body of literature that focuses on refugee policies and health status, there are very few studies that report on systematic, methodologically rigorous interventions employing health, welfare and resettlement strategies.

Table 2 below highlights empirical evaluations of therapeutic interventions with refugees specifically in the context of resettlement. Intervention studies were selected by interrogating PsycINFO and PUBMED for studies conducted with refugees and published in English in the last 25 years. Research dissertations were excluded from the search. Only intervention studies (a) involving refugees that (b) were evaluated empirically, (c) contained a minimum of 10 participants, and (d) were conducted in resettlement countries were included. There were several published reports of case studies and interventions with smaller samples but they were not selected for further analysis on the basis that calculations of the magnitude of therapeutic outcomes would be questionable. The existing evaluations tend to be limited by small sample sizes, lack of control groups, and absence of standardised evaluative measures assessing long term change. Therefore, evaluation of those interventions should be viewed with caution.

It is important here to acknowledge a range of other literature that deals with treatment of victims of torture and trauma who may not fit the above definition of refugee, first or second country interventions with refugee claimants prior to their being resettled in their country of destination, and interventions that have not been evaluated empirically according to the minimum evaluation standards applied in this literature review. We consider some trends in that other work briefly. Basoglu's (1992) summary put the percentage of refugees who had been tortured and were experiencing PTSD at around 63%. Campbell claimed that the percentage of refugees who have experienced torture can vary from between 5% and 35%. Basoglu (2006) has argued that although CBT has been demonstrated to be an effective treatment for traumatised survivors of traumatic events such as earthquake, there is not a lot of evidence supporting its effectiveness with survivors of torture. Basoglu noted a trend toward using short-form exposure therapies with these survivors, for which preliminary evidence was encouraging. Campbell (2007) reported on the effective use of CBT with torture survivors experiencing PTSD and depression. A review by Nicholl and Thompson (2004) of therapeutic interventions with refugees experiencing PTSD, provides evidence that CBT and expressive therapies, while apparently beneficial, have had limited testing. There were methodological limitations to the studies reviewed, and often reliance on anecdotal evidence of positive outcomes.

The need for theoretically driven and empirically validated treatments with refugee populations has been recognised already and the majority of evaluations have taken place in the last ten years. A sizeable number of books on therapeutic interventions suitable for use with refugees have appeared recently. Writings such as these, as well as literature drawn from other relevant sources such as transcultural psychiatry, medical anthropology, and immigrant mental health, provide a starting point for practitioners.

Several specific treatments have been evaluated in a few smaller scale studies and some promising treatment models have emerged. Testimonial psychotherapy has been evaluated with child and adult populations (Agger & Jensen, 1990; Lustig, Weine, Saxe, & Beardslee, 2004; S. Weine, Kulenovic, Pavkovic, & Gibbons, 1998). Testimonial psychotherapy involves the creation of a written document over the course of sessions which, upon completion, can be used for documentary or political purposes (Ehntholt & Yule, 2006). Agger and Jensen advocate that "testimony as a way of getting rid of internal 'evil' would seem to be a universal phenomenon" (1990, p. 116). In a pilot study with 20 Bosnian refugees, Weine et al. (1998) administered typically 6 sessions of testimonial psychotherapy and found rates of PTSD diagnosis dropped from 100% pre-testimony to 53% at 6 months post-treatment.

A related treatment, Narrative Exposure Therapy (NET), involves the retelling of one's entire life with detailed accounts of traumatic experiences. The treatment targets the emotional reactions to trauma by using exposure and habituation and working to develop a coherent autobiographical account (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). NET has been used in Uganda with Sudanese refugees by Neuner et. al. and has been linked with significant reductions in symptomatology (Neuner et al., 2004; Onyut et al., 2005). One study of 43 adults found rates of PTSD one year post-treatment among individuals who received NET dropped to 29%, compared with those who received supportive counselling, where rates remained high at 79%, or psycho-education, at 80% (Neuner et al., 2004).

Cognitive Behavioural Therapy (CBT) is one of the traditional treatments for PTSD (Foa, 2000). There has been a small number of studies examining the effectiveness of CBT in producing symptom reduction for refugee children and adults (Basoglu, Ekblad, Baarnhielm, & Livanou, 2004; Ehntholt, Smith, & Yule, 2005; Otto et al., 2003; Paunovic & Ost, 2001). The outcomes from these small-scale clinical interventions using CBT separately or in combination with other therapeutic approaches have generally been very positive. One comparative trial of CBT and exposure therapy found that both treatments were effective in reducing symptoms of PTSD, anxiety and depression among refugees with results lasting through to 6 month follow-up evaluations (Paunovic & Ost, 2001). CBT, when combined with psychopharmacological treatment, resulted in reduced PTSD and associated symptoms (Otto et al., 2003). D'Ardenne et al. (2007) reported that CBT was effective in treating symptoms of traumatic stress and depression, irrespective of whether or not refugee clients required the assistance of an interpreter.

Other innovative interventions have been developed to recognise special concerns and priorities within refugee communities. For example, rates of illiteracy may be much higher than are found in mainstream Western societies. Therefore, expressive therapies such as NET or music and art therapy may be more appropriate, or be a useful supplement to other forms of therapy, when working with refugees. These results also suggest other modifications that might be made to mainstream psychological interventions, such as presenting information in visual formats through videos and pictures.

Other writers have advocated using family interventions, particularly among refugee groups coming from more collectivistic and family-oriented cultures. Weine et al. (2003) evaluated a multi-family intervention in Chicago which included 7 sessions with families recently arrived from Kosovo. Following the family support and psycho-education intervention, families showed increases in social support, utilisation of psychiatric services, positive changes in trauma mental health knowledge and attitudes, and family hardiness. Using family-oriented interventions may be helpful, particularly when intergenerational issues, family conflict and difficulties in resettlement are among clients' primary presenting concerns.

Future clinical interventions would benefit from the systematic development of culturally competent programs based on individual and community needs. For example, Transcultural Psychosocial Organisation has constructed a 9 step model for developing culturally sensitive, community oriented interventions and currently has 400 staff working in 15 countries through Europe, Africa and Asia (Eisenbruch, de Jong, & van de Put, 2004). Their framework combines intervention and action research by working with local organisations to develop culturally competent programs that are designed to meet local needs. Other approaches have sought to develop better connections between the numerous centres and organisations that are dedicated to providing mental health services for refugees. For example, the International Rehabilitation Council for Torture Victims (http://www.irct.org/Default.aspx?ID=1) provides listings of associated torture and trauma centres located around the globe.

Such networks and resources ensure practitioners are able to access this information and provide the best treatment possible, while building on previous efforts rather than reinventing existing approaches. As the numbers of refugees remain exorbitantly high and more refugees are being settled in new countries and communities, there is an increased need to collaborate and share resources and expertise. Collaboration among psychologists as well as between psychologists and other service providers and disciplines is critical to ensure systems and services continue to evolve and improve.

A number of therapeutic interventions to reduce refugees' symptoms of distress have been tested, including CBT, testimonial psychotherapy and narrative exposure therapy. In summary, these therapeutic interventions have been limited by small sample sizes, lack of control groups, and absence of standardised evaluative measures assessing long term change, requiring caution when interpreting their results. Notwithstanding, demonstrated outcomes of the interventions have been promising. We recommend further advancement of empirically validated interventions for refugees.

Gonsalves (1992) maintained that resettlement involves a stage-like unfolding of everyday personal and social challenges (tasks) accompanied by quite specific therapeutic needs. Individual refugees differ in terms of the duration of each stage, and the extent to which they successfully manage the everyday challenges and levels of psychological distress that accompany success or failure on those challenges. Gonsalves also proposed that mental health interventions, and the roles of practitioners who deliver them, need to change in accordance with clients' changing therapeutic needs, and that therapeutic interventions need to be tried and evaluated with refugee clients who are at different stages of resettlement. The possibility that different intervention approaches may have differential success depending on the stage of resettlement should not be dismissed.

Guidelines for Psychologists Providing Services for Refugees

In our review of relevant literature we were unable to locate any comprehensive practice guidelines designed specifically for psychologists who provide services for refugees. There is also an absence of comprehensive ethical guidelines for psychologists providing those services.

Although the new Code of Ethics of the Australian Psychological Society (2007) mandates psychologists to respect and protect people's human rights (General Principle A), avoid unfair discrimination (Standard A.1.1), demonstrate knowledge of the consequences of unfair discrimination (Standard A.1.2) and assist clients to address unfair discrimination (Standard A.1.3), it does not mandate an advocacy role for psychologists. There is a need, therefore, for ethical guidelines containing discretionary provision for health professionals to advocate on behalf of refugee clients in order to bring to an end future unjust or inhumane treatment (Kisely, Stevens, Hart, & Douglas, 2002; McNeill, 2003; Silove, 2002). That may mean for example, psychologists not working in conditions that adversely affect refugee mental health and finding alternative options, and separating the roles of detention contractors from health care contractors who provide staff and services in immigration detention facilities (Fazel & Silove, 2006). It also means working to ensure equitable access and to remove barriers to quality care, as well as the development of new models of service delivery to match services to the needs of individuals and communities in various settings (Kelaher & Manderson, 2000).

The literature search did uncover a comprehensive set of standards for providing health services in Australian immigration detention centres (RACGP, 2007) and partial practice guidelines or steps designed to facilitate high standards of service delivery. There are also the Australian Guidelines for the Treatment of Adults with ASD and PTSD (Australian Centre for Posttraumatic Mental Health (ACPMH) (2007) that offer specific guidelines for working with "refugees and asylum seekers" (pp. 137-141). The RACGP (2007) and ACPMH (2007) standards and guidelines are now summarised briefly.

The RACGP (2007) standards apply specifically to the delivery of services in immigration detention facilities. They cover secondary and tertiary health service delivery and health promotion, patient (sic) rights, quality maintenance and professional development needs of health service providers, health service and health information management, and facilities. The standards regard mental health as a subset of all health care to which they apply. Psychology is classified with other allied health which, in the application of the standards, is not treated differently from clinical health. The standards acknowledge that "[t]here is some evidence that detention itself may impact on mental health and that the detention context, immigration administrative processes (e.g. appeals processes) and associated stressors may exacerbate symptoms of psychological morbidity for people detained in immigration detention facilities"; and that a "number of studies [of refugee claimants in immigration detention] have demonstrated higher than average levels of mental illness and psychiatric morbidity including high rates of suicide, depression, hunger strikes, post-traumatic stress, anxiety and panic among asylum seeker populations worldwide" (p.6).

The RACGP (2007) standards articulate a number of generic expectations of quality health care. Clinical and allied health care should be continuous, comprehensive and coordinated. A range of services should be available to meet the clinical, mental and other health care needs of detainees. Consultations should vary according to the client's particular health care need.

There are parts of the RACGP standards that might be applied specifically to mental health care. They contain explicit requirements about health information and health records management. Emphasis is placed on client privacy and consent, with the release of information or records to government agencies, detention services personnel and other professionals without client consent being strictly for purpose of preventing imminent harm to the client or others and strictly in accordance with legal requirements. Provision of multilingual information and interpreting services for clients is recommended. Clinical and allied health providers should have the opportunity to refer clients to other health providers within a centre to ensure that the specialist health care needs of clients are met. Provision should be made for the transfer of client care, if required. Finally, client history taking and client records should include information on the client's family and social background, as well as the clinical history (RACGP, 2007).

The ACPMH (2007) Guidelines frame trauma-like symptoms found in refugee populations within the generic DSM-IV model of PTSD. Consequently, recommendations contained in the Guidelines for assessment and treatment of trauma symptoms are consistent with the assessment and treatment approaches recommended for sufferers from other populations such Indigenous Australians and military and emergency services personnel. Notwithstanding, the ACPMH Guidelines (2007) emphasise the complex relationships that exist in refugee populations between refugees' previous and current socio-political circumstances, cultural and linguistic backgrounds, traumatic exposure, and symptom presentation, each of which is examined in more detail, and recommend thorough assessment of all these factors. Although the Guidelines advocate for holistic approaches to assessment and treatment, they suggest, in keeping with their medicalised philosophy of trauma, that the primary focus of treatment should be on symptomatic relief from the trauma effects: "The middle ground, in which the practitioner is mindful of ethnocultural issues, but does not attempt to deal with them as the end in itself, is ideal. The practitioner's genuine interest and respect are the most effective tools for building trust and the positive therapeutic relationship needed to help the individual recover from their traumatic experience (p.137)."

Further work is required if the ACPMH standards are to be applied comprehensively to the provision of psychological services that meet the ethical and practice standards of the Australian Psychological Society.

Davidson et al. (2004) explored a number of social and cultural factors that might influence the level of cultural sensitivity exercised in health care delivery for refugees. In order to address some of those factors, Davidson et al. (2004) recommended that service providers make use of interpreting services. To assist with the challenges associated with the use of interpreters, Davidson et. al. (2004) developed a checklist of things to consider and do when interpreters are used to assist with the provision of health services for refugees. The checklist includes decisions that should be made prior to client consultations, including: the selection of interpreters and preparing for the consultation; matters that might be covered during the consultation which ensure that the service provider through the interpreter obtains the client's cultural perspective on the presenting problem, service being provided and follow-up required; and matters that require attention after the consultation, including obtaining pharmaceuticals or clinical tests. The checklist, if slightly adapted, provides a useful framework for engaging interpreting services to assist with psychological service delivery. The Victorian Transcultural Psychiatry Unit (2006) has also published an expansive set of guidelines for mental health professionals who engage the services of interpreters.

Procter (2005a) developed a checklist for emergency mental health nurses to assist with the building trust between clients and the mental health worker. The steps include engagement of a suitable interpreter, clarification of the client's expectations, the presenting problem, the mental health worker's role, the services that will be provided, outcomes that might be reasonably expected, and the role of, and support available for, associated parties such as family members. Proctor's checklist lends itself readily to adaptation by psychologists working with refugee clients.

Procter (2005b) has constructed a short checklist of matters to be considered by mental health professionals working with TV holders and refugee claimants whose claims have been rejected. Procter's checklist, which focuses on the stage immediately following rejection of the claim (the "acute" stage), provides guidance around: the establishment and engagement of a collaborative team that involves the mental health professional, interpreter, treating physician and other professionals connected with the case; assessment of the risk of harm by the client to himself or herself and others, including members of the professional team; and applying "mental health first aid" if clients become very distressed. Once again, the checklist might easily be adapted and included in a comprehensive set of practice guidelines for psychologists.

Finally, the APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association, 2003) are generally relevant for guiding service provision for clients from culturally and linguistically diverse backgrounds. The Guidelines make specific mention of psychological service provision for refugees. They enjoin psychologists to familiarise themselves with the psychological, social and cultural issues confronting refugee clients and communities, develop an understanding of factors that shape personal, social and cultural identity of clients and communities, and explore clients' changed social circumstances and educational costs linked with being a refugee.

In summary, useful practice and ethical checklists exist for psychologists who are engaged in providing services for refugee clients and communities, irrespective of their visa status. However, these guidelines need to be consolidated and adapted into a comprehensive set of guidelines that have specific relevance for the provision of psychological services and are commensurate with existing ethical standards and guidelines in psychology.

In addition to the development of practice guidelines that deal with psychological assessment and therapeutic interventions for refugees, there is the need to consider the ethical dilemmas that these services raise for professionals. Century et al. (2007) interviewed mental health counsellors working with refugee clients in Britain. Counsellors reported feeling "conflicted, troubled and out of their depth by experiences" in addition to having to face a range of ethical challenges (p.23). The ethical challenges include the blurring of provider-client boundaries when individuals have different expectations of

provider and client roles (Savin & Martinez, 2006). Savin and Martinez (2006) advocate a more flexible model of ethics whereby clinicians use a graded risk assessment approach to determine what is the most acceptable and defensible therapeutic course of action. Ethical guidelines that elaborate on the APS Code of Ethics would be beneficial for psychologists who are required to manage the ethical distress (see Jameton, 1984) that arises when refugee clients' expectations about advocacy support conflict with the psychologist's assessment or therapeutic roles or when the best interests of clients, employers and government authorities collide.

Toward Good Practice in the Provision of Psychological Services for Refugees

Over the last 25 years, a global interest in the mental health of refugees has generated a significant body of research which permits some conclusions regarding good psychological practice with refugees in resettlement countries. Refugees frequently struggle to overcome the psychological impacts of personal safety threats and of social and cultural dislocation. Furthermore, they face additional social, linguistic, educational and vocational challenges throughout their attempts to obtain asylum and following resettlement. In order for psychology to assist refugees to respond effectively to these traumas and stresses, psychologists require therapeutic interventions that respond holistically the unique experiences of individuals and families. The first and foremost need that should be recognised is to assist refugees to "develop a sense of stability, safety and trust, as well as to regain a sense of control over their lives" (Ehntholt & Yule, 2006, p. 1202).

Selection of valid and reliable methods of assessing refugees' cognitive capacity, neuropsychological functioning, mental health status, linguistic ability, and psycho-educational needs is an important first step in preparing for an intervention. Psychologists also need to find ways of offering expert input on methods for evaluation of claims for refugee status. More work needs to be done to refine existing psychological tests and tools and to develop new instruments in order to improve the validity and reliability of measures of refugees' psychological functioning.

When working with refugees, practitioners are forced to start "rethinking a familiar model" of psychotherapy to accommodate the cultural and linguistic backgrounds of clients (Miller, 1999). This may involve recognising therapeutic alternatives to traditional psychotherapy and to biomedical interventions. Testimonial psychotherapy and Narrative Exposure Therapy have been shown to be effective therapeutic interventions, as has CBT. It is also important to recognise that the needs of refugees from widely different cultural and ethnic backgrounds may be dissimilar (Measham, Rousseau, & Nadeau, 2005; Morris & Silove, 1992). Alternative approaches may include the use of traditional healers, family or community-based approaches, and cross-disciplinary collaborations (Miller & Rasco, 2004; Williams, 1989), in addition to the approaches that have been tested. Therapeutic interventions should always include a methodologically defensible evaluation mechanism.

The dynamics of treatment become more complex when working with individuals from different cultural and linguistic backgrounds. Problems with miscommunication may arise frequently (Guerin, Guerin, Diiriye, & Yates, 2004) and access to regular, expert interpreting services may be limited (Century et al., 2007). The engagement of bicultural workers and cultural liaison officers, as well as provision of appropriate cultural training for psychologists, are critical for valid and reliable interpretation of unique expressions of distress and presenting symptoms (Gozdziak, 2004). The hiring, training and support of interpreters and practitioners is a critical but often overlooked dimension of therapy. Development of training programs for psychologists who work with refugees is recommended (Gozdziak, 2004; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Practice guidelines adapted from existing practice guidelines and checklists for medical and nursing personnel who work with refugees, and ethical guidelines that offer additional guidance on managing ethical dilemmas and distress that confront psychologists working with refugees, would assist in determining the nature and scope of such training and provide practitioners with a ready reference for use in practice settings.

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Appendices

Table 1. Measures developed, adapted and used with refugee populations

Measure	Format	Validation	Reference
Harvard Trauma Questionnaire (HTQ)	3 sections: traumatic experiences (17 items); subjective descriptions most traumatic event(s); symptoms (30 items)	91 Indochinese refugees; Cronbach's alpha .90 (trauma events) and .96 (trauma symptoms)	Mollica, R.F. et al. (1992). The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *J Nerv Ment Dis 180 (2)*, 111-116.
Hopkins Symptom Checklist (HSCL)	25 items; anxiety (10 items) and depression (15 items)	231 refugees outpatient clinic;	Lavik, N.J. et al (1999). The use of self-reports in psychiatric studies of traumatized refugees: Validation and analysis of the HSCL-25
Impact of Events Scale	15 items PTSD symptoms; 3 factors (intrusion, avoidance, and emotional numbing)	180 Khmer refugee youth; Cronbach's alpha = .92	Sack, W.H. et al. (1998). Psychometric properties of the Impact of Events Scale in traumatized Cambodian refugee youth. *Personality and Individual Differences, 25*,57-67.
Impact of Event Scale for Children (R-IES) for PTSD symptoms	13 items; 2 factors (intrusion and arousal, avoidance)	2976 Bosnian youth (9-14 year old); Cronbach's alpha = .80	Smith, Perrin, Dyregrov, & Yule (2003). Principal components analysis of the impact of event scale with children in war. *Pers and Ind Differences 34(2)*, 315-322.
Afghan Symptom Checklist	22 items; 3 factors (sadness with social withdrawal and somatic distress, ruminative sadness without social withdrawal and somatic distress, and stress-induced reactivity	324 adults in 8 districts of Kabul; Cronbach's alpha = .93	Miller et al. (2006). The Afghan Symptom Checklist: A culturally grounded approach to mental health assessment in a conflict zone. *Am J of Orthopsychiatry, 76(4)*, 423-433.
Posttraumatic Stress Scale (PTSS-10)	10 items; posttraumatic stress symptoms	206 Bosnian refugees; Cronbach's alpha = .92	Thulesius, H. & Hakansson, A. (1999). Screening for Posttraumatic Stress Disorder symptoms among Bosnian refugees. *J of Traum Stress, 21(1)*, 167-174.
Comprehensive Trauma Inventory (CTI-164)	164 items, war-related events	36 Kurdish and 31 Vietnamese refugees; focus groups	Hollifield, M., et al. (2005). Development of an inventory for measuring war-related events in refugees. *Compr Psychiatry, 46(1)*, 67-80.
Child Behavior Checklist (CBCL) for unaccompanied minors	118 problem behavior items; internalizing and externalizing behaviors (8 subscales)	920 guardians of unaccompanied refugee minors; total alpha = .94	Validation of the child behavior checklist for guardians of unaccompanied refugee minors. *Children and Youth Services Review, 28*, 867-887.
Teacher Report Form (TRF) for unaccompanied minors	101 items; internalizing and externalizing behaviors (8 subscales)	486 teachers of unaccompanied refugee minors; total alpha = .95	Bean et al. (2007). Validation of the Teacher's Report Form for teachers of unaccompanied refugee minors. *J of Psychoeducational Assessment, 25(1)*, 53-68.
Reactions of Adolescents to Traumatic Stress	22 items; 3 factor (intrusion, avoidance/numbing, hyperarousal)	3,535 refugee and control adolescents; total sample alpha = .91	Bean et al. (2006). Validation of the multiple language versions of the Reactions of Adolescents to Traumatic Stress questionnaire. *J of Traumatic Stress, 19(2)*, 241-255.

Table 2. Evaluated interventions for refugees in settlement

Reference	Treatment	Study details	Outcomes
Baker & Jones (2006). The effect of music therapy services on classroom behaviours of newly arrived refugee students in Australia-a pilot study. Emot and *Behav Difficulties, 11(4)*, 249-260.	Music therapy: • Group music therapy • 1 or 2 times per wk • 2 five-wk intervention periods; Cross-over design	• 31 students from intensive English school • 5 assessment points (pre/post-intervention and at each 5-wk block) • Teacher assessment of child behaviour	• Significant changes in externalizing and internalizing behaviours, BSI and school problems but not for adaptive skills • Long-term (5-wk) intervention effect for externalizing behaviors (BASC)
Barrett, P.M., Moore, A.F., Sonderegger, R. (2000). The FRIENDS program for young former-Yugoslavian refugees in Australia: A pilot study. *Behaviour Change, 17(3)*, 124-133.	CBT: • Anxiety-reduction program • 10 wk program, once per wk	• 9 treatment and 11 wait-list controls • Mean age = 16.6	• Treatment condition reported significantly lower internalizing symptoms
Ehntholt et al (2005). School-based cognitive-behavioural therapy group intervention for refugee children who have experienced war-related trauma. *Clin Child Psychol and Psychiatry, 10(2)*,235-250.	CBT: • 6 sessions group CBT • 1 per wk • Wait list control group	•26 refugees or asylum seekers • Aged 11-15 years • 15 CBT group and 11 wait list controls	• CBT showed statistically significant, but clinically modest improvements post-intervention • Significant improvements overall behavioural difficulties and emotional symptoms. • Control group did not show any improvements over the same period. • Follow-up only with 8 and no changes maintained at 2 months post intervention.
d'Ardenne, P., Ruaro, L., Cestari, L., Fakhoury, W., & Priebe, S. (2007). Does interpreter-mediated CBT with traumatized refugee people work? A comparison of patient outcomes in East London. *Behavioural and Cognitive Psychotherapy, 35(3)*, 293-301	CBT • Retrospective study • Weekly or fortnightly • Average 9 sessions	• 44 refugees requiring interpreters • 36 refugees not requiring interpreters • 48 non-refugee patients • All completed at least 2 of 3 pre/post assessments	• Refugees with and without an interpreter did not differ in outcomes • Significant outcomes for all groups post treatment (IES, BDI)
Goodkind, J.R. (2005). Effectiveness of a community-based advocacy and learning program for Hmong refugees. *Am J Com Psych, 36*(3-4), 387-408.	Mutual learning groups: • 6 month program, 6-8 hours per wk • 5 domains: psychological wellbeing, quality of life, access to resources, English proficiency, knowledge for U.S. citizenship exam	• 28 Hmong adults and 27 undergraduate students; No control grp • 4 assessment points (every 3 months pre/post and during intervention)	• Participants' quality of life, satisfaction with resources, English proficiency, and knowledge for the U.S. citizenship test increased • Levels of distress decreased over the course of the intervention • Improved QOL mediated by improved satisfaction with resources
Oras et al (2004). Treatment of traumatized refugee children with Eye Movement Desensitization and Reprocessing in a psychodynamic context. Nord J *Psychiatry, 58(3)*, 199-203.	EMDR with conversational therapy or play therapy: • 5 to 25 sessions • 1 or 2 per wk • No control group	• 13 refugee children • 10 boys • All under 13 yrs	• Post treatment, significant improvement in all PTSS-C scales. The improvement in the functioning level (GAF) significantly correlated with the reduction of the PTSD-non-related and the depression, but not with that of the PTSD-related symptoms
O'Shea et al. (2000). A school-based mental health service for refugee children. *Clin Child Psychol and Psychiatry, 5(2)*, 189-201.	School-based program: • Family appointments • 1 per week for term • Mean = 5.5 appointments for children	• 14 refugee children and their parents; no control grp • 12 boys • Assessment pre/post-intervention	• Reduction in SDQ (Strengths and Difficulties Questionnaire) from 21.3 to 15.7 (n = 12) • 2 case examples provided
Otto et al. (2003). Treatment of pharmacotherapy-refractory posttraumatic stress disorder among Cambodian refugees. *Behaviour Research and Therapy, 41*, 1271-1276.	CBT and PT (Sertraline): • Random assignment to PT (n = 5) or combined CBT & PT (n = 5) • 10 sessions group CBT	• 10 adult Khmer females • Mean age = 47.2 years • Not responsive to previous medications and tapered off existing meds • Assessment pre/post-intervention	• Combined treatment offered additional benefit (medium to large effect sizes) for PTSD and associated symptoms

Table 2. Evaluated interventions for refugees in settlement			
Paunovic & Ost (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behaviour Research and Therapy, 39*, 1183-1197.	CBT and E: • Randomized assignment to CBT or E • 1 per week for 16-20 sessions • 60-120 minute sessions	• 16 outpatients meeting DSM-IV criteria for PTSD • Assessment pre/post-intervention and 6 month follow-up	• CBT and E had large improvements on all measures and no difference between groups • Results maintained at 6 month follow-up • E led to a 48% reduction on PTSD-symptoms, 49% generalized anxiety, and 54% depression • CBT led to 53% reduction PTSD-symptoms, 50% generalized anxiety, 57% depression
Rousseau et al (2005). Evaluation of a classroom program of creative expression workshops for refugee and immigrant children. *J Child Psychol Psychiatry, 46(2)*, 180-185.	Creative Expression Workshops: • 12 week program • Tx (n = 73) and control (n = 65) groups—assigned by classroom • 2 hours per week, within classroom setting	• 138 immigrant and refugee children • aged 7 to 13; 81 boys and 57 girls • Assessment pre/post-intervention of students and teachers	• Experimental groups (compared to controls, and control for baseline) 2 weeks post-intervention had: – Lower mean levels of internalizing and externalizing symptoms – Higher mean levels of feelings of popularity and satisfaction • Effect on internalizing and externalizing symptoms was not modified by gender, age or fluency in the mainstream language
Snodgrass et al. (1993). Vietnamese refugees with PTSD symptomatology: Intervention via a coping skills model. *J of Traum Stress, 6(4)*, 569-575.	Coping Skills Model (adaptation of SIT program for victims of rape): • 6 x 3 hour sessions • Tx group were undergraduate students enrolled in course and controls selected by participants	• 8 Vietnamese undergraduate students; mean age = 19.3 • 6 controls selected by students (relative or friend) • Assessment pre/post-intervention	• Equivalent pre-treatment PTSD symptom scores • Significant reduction among Vietnamese SIT in PTSD symptoms post-intervention • No significant change in PTSD symptoms for controls post-intervention
Smajkic, A., Weine, S., Djuric-Bijedic, Z., Boskailo, E., Lewis, J., & Pavkovic, I. (2001). Sertraline, paroxetine, and venlafaxine in refugee posttraumatic stress disorder with depression symptoms. *J Trauma Stress, 14(3)*, 445-452.	PT • Open trial • 6 weeks • Concurrent case management and SC	• 32 Bosnian refugees • 18 women, 14 men • Mean age = 51.34 • Sertraline (n = 15) Paroxetine (n = 12) Venlafaxine (n = 5) • Pre/post-treatment assessment and 6 wk follow-up	• Sertraline and Paroxetine: statistically significant improvement at 6 weeks in PTSD symptom severity, in depression, and in GAF scores. • Venlafaxine: improvement in PTSD symptom severity and in GAF, but not symptoms of depression and had a high rate of side effects • All refugees remained PTSD positive at the diagnostic level at the 6-week follow-up
Weine et al (1998). Testimony psychotherapy in Bosnian refugees: A pilot study. *Am J of Psychiatry, 155*, 1720-1726.	Testimonial psychotherapy: • Average 6 sessions • 90 minutes every 1 to 2 wks • No control group	• Case series 20 Bosnian refugees • 12 men, 8 women; mean age = 45.1 years • 4 assessment points: pre/post-intervention and 2- and 6-month follow-ups	• Decreases in the rate of PTSD diagnosis, PTSD symptom severity, and depressive symptoms • Significant increase in scores on the GAF (63.0 pretestimony to 87.0 at 6-month follow-up)
Weine et al (2003). The TAFES multi-family group intervention for Kosovar refugees: A feasibility study. *J Nerv Ment Dis, 191(2)*, 100-107.	Family intervention: • 6 wk program over 8 wk period • No control group	• 42 Kosovar families • 2 assessment points (pre- & 2 month post-intervention)	• Increases in social support and psychiatric service use • Changes in scale scores assessing trauma mental health knowledge and attitudes, and family hardiness
Key: BASC = Behaviour Assessment System for Children; BDI= Beck Depression Inventory; CBT = Cognitive Behavioural Therapy; DSM-IV = Diagnostic and Statistical Manual-Fourth Edition; E = Exposure Therapy; EMDR = Eye Movement Desensitization and Reprocessing; GAF = Global Assessment of Functioning Scale; IES = Impact of events scale; n = sample size; PT = Psychopharmacological Treatment; PTSD = Posttraumatic Stress Disorder; SC = Supportive Counselling; Tx = Treatment			

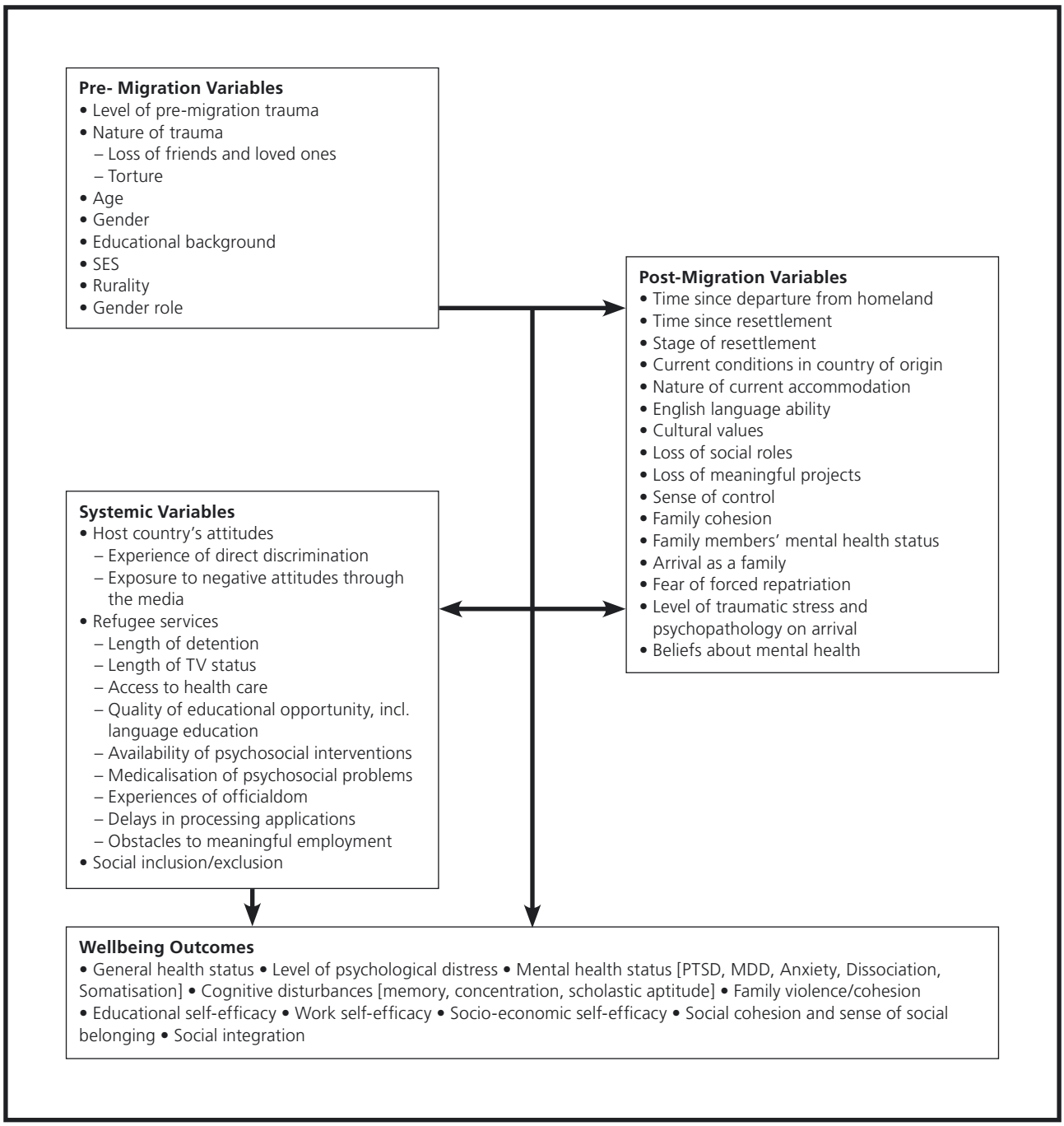

Figure 1. Path representation of pre- and post-migration factors impacting on refugees' psychological well-being.